

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
04-009

2. STATE
Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
11/01/04

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(64) SSA

7. FEDERAL BUDGET IMPACT:

a. FFY 2005 — \$8,881K
b. FFY 2006 — \$9,684K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

Attachment 4.19B, page 7
Attachment 4.19B, page 7a

Same
New

10. SUBJECT OF AMENDMENT:

End stage renal disease reimbursement rates.

11. GOVERNOR'S REVIEW (*Check One*):

- ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT *Robert Blum*
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark B. Moody

14. TITLE:

Administrator, Division of Health Care Financing

15. DATE SUBMITTED:

09/29/04

16. RETURN TO:

Mark B. Moody
Administrator
Division of Health Care Financing
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

9/30/04

18. DATE APPROVED:

10/14/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

November 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED

SEP 30 2004

DMCH - MI/MN/WI

7. End Stage Renal Disease

The Department will pay free-standing End Stage Renal Disease (ESRD) providers the Medicare reimbursement rate for the services that they provide.

Effective 11/01/04

8. Case Management Services
EPSDT

Providers are reimbursed by a flat fee which is a percentage of the provider's average cost, established by the Department.

Effective 4-8-86

9. Case Management Services
Community Care Organizations

For case management services performed by Community Care Organizations, reimbursement will be made through the per diem rate as established by the department.

Certified providers will be reimbursed upon submission of an appropriate claim form, documenting recipient eligibility and services provided. This is true for all other MA-certified providers. Payments made from Title XIX funds for MA eligible clients will be appropriately matched with state and local funds, and will not duplicate other federal or state payments or match requirements.

Effective 10-1-86

9a. Case Management Services
Target Group N

This rate applies to clients in Target Group N where the child has been placed in substitute (out-of-home) care determined to be ineligible for Title IV-E administrative costs. The Department's proposal requires no change in the definition of the existing group and the benefits remain the same.

The rate methodology will employ the Random Moment Time Study (RMTS) as a tool in developing the monthly rate per client. The billing process will be established in such a manner as to prevent the processing of duplicate billings for the same client for the same service period. This will be accomplished by installing edits between procedure codes in the MMIS system. The methodology also contains a provision for adjusting the rate to an actual cost basis after completion of the Federal Fiscal Year.

Effective 10-1-01